

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01370

CERTIFICATE OF DEATH

01353

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>650 Washington St</u>		d. STREET ADDRESS <u>650 Washington St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>(Schwal)</u> Last <u>Arendes</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 13, 1883</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Henry C. Schwal</u>		14. MOTHER'S MAIDEN NAME <u>Mary Van Dusen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Philip J. Arendes</u>		Address <u>Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, left, with L. hemiplegia</u> DUE TO (b) <u>Hypertension and A. S. vascular disease</u> DUE TO (c) <u>?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 Dec., 1958</u> , to <u>23 Feb., 1962</u> , that I last saw the deceased alive on <u>22 Feb., 1962</u> , and that death occurred at <u>12 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Alfred Van Ormer</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Bldg., 122 S. Centre St.</u> DATE SIGNED <u>2/26/62</u>	
PHYSICIAN'S NAME (Type) <u>W. Alfred Van Ormer, M. D.</u>		<u>Cumberland, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/26/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 28 1962</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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THE UNIVERSITY OF CHICAGO PRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, place 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
01371													
CERTIFICATE OF DEATH													
Item 9 Film G308 3/5/62 iwk													
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT 1 BOX 223 FROSTBURG, MD. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JENNIE B. BARBER						4. DATE OF DEATH 2/20/1962							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 28, 1887		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DECEASED						14. MOTHER'S MAIDEN NAME DECEASED							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT CHART Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation 144X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) metastases to neck & lungs (c) Carcinoma Sq. Cell Left Alveolar Nodular PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH 3 mo 6 mo 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from July 6, 1961 to Feb 20, 1962 that (I) (we) last saw the deceased alive on Feb 20, 1962 and that death occurred at 5 P.M. from the causes and on the date stated above.													
22a. SIGNATURE R. Phitt Reddhone M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type)						22b. DATE SIGNED							
22d. ADDRESS Medical Bldg, Cumberland, Md													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)					
Burial		2/23/1962		Eckhart Cemetery		Eckhart, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, MD.						25a. REC'D BY REGISTRAR FEB 26 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House					



George Stephens
Lonsdale, W.
2, 22/23es - Belgrave Cemetery
Lonsdale, W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 521 HILL TOP DRIVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PHILLIP Middle BARKMAN Last				4. DATE OF DEATH Month FEBRUARY Day 7 Year 19 62			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1892		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED -Supt.		10b. KIND OF BUSINESS OR INDUSTRY Steel Industry		11. BIRTHPLACE (County & State, or foreign country) MARYLAND -FLINTSTONE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN F. BARKMAN				14. MOTHER'S MAIDEN NAME DOROTHY HERBST			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-9505		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease - for advanced myocardial infarction DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enlarged Prostate - removed				INTERVAL BETWEEN ONSET AND DEATH 4-20-62			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
2Dc. TIME OF INJURY Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-24 4:40 A.M. 2-7-62 , that (I) (we) last saw the deceased alive on 2-6-19-62 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE W. F. Williams M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/7/62	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS				22d. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 10, 1962		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR FEB 14 '62		25b. REGISTRAR'S SIGNATURE William S. Turner	



01332

01332

RE ORILL HOSPITAL

6 DAYS

CUMULATIVE

SET FILE FOR DRIVE

PHILIP

BARON

FEBRUARY 7

WILE - WHITE

1-1-1968

60

WILSON - BUTCH

1-1-1968

WILSON - BUTCH

BENJAMIN E. BARNES

DOROTHY LARSEN

1-1-1968 RE ORILL HOSPITAL - CUMULATIVE, WILSON

[Handwritten signature]

[Handwritten signature]

DR. W. T. WILLIAMS

122 S. CLARE STREET, CUMULATIVE

James T. Williams, Esq.

122 S. CLARE STREET, CUMULATIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

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01373
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
04850
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 24 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 420 LOUISIANA AVE.			
3. NAME OF DECEASED (Type or print) CHARLES A. BARRINGER				4. DATE OF DEATH FEB. 5, 1962			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-13-1887	
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Printer		11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME REDWINE BARRINGER				14. MOTHER'S MAIDEN NAME LELIA C. NASH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes War I				16. SOCIAL SECURITY NO. 214-05-7258			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis, marked 334-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 8 yrs.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-12-8:30 P.M. to 2-5-62 , that (I) (we) last saw the deceased alive on 2-5-1962 , and that death occurred at 2-5-1962 , from the causes and on the date stated above.							
22a. SIGNATURE W. F. Williams M.D.				22b. DATE SIGNED 2-7-62			
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS				22d. ADDRESS 122 S. CENTREST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 8, 1962		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR FEB 13 '62			
ADDRESS James F. Scarpelli, Cumberland, Md.				25b. REGISTRAR'S SIGNATURE Charles S. Kline			



01373

01373

CERTIFICATE OF DEATH

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WATLAND

ALLICAMP

WATLAND

WATLAND

21 DAYS

GENERAL HOSPITAL
GENERAL X-RAY 100 WAYS

GENERAL HOSPITAL
GENERAL X-RAY 100 WAYS

THAYER

BARNES

FEES

WHITE

7-12-1907

74-

REOVIC BARNES

REOVIC BARNES

21-11-1907

21-11-1907

General Hospital - General X-Ray

General Hospital - General X-Ray

General Hospital - General X-Ray

155 S. CENTRAL ... GENERAL HOSPITAL

155 S. CENTRAL ... GENERAL HOSPITAL

General Hospital - General X-Ray

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01374

Item 2 Film G307

2/19/62 ink

01357

1. PLACE OF DEATH a. COUNTY ALLEGANY CUMBERLAND MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. MARYLAND Pa. b. COUNTY BEDFORD	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		d. STREET ADDRESS RT#3	
3. NAME OF DECEASED (Type or print) First ALPHA Middle PEARL Last BENNETT		4. DATE OF DEATH Month FEB Day 11 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-23-1905
9a. AGE (In years last birthday) 56 yrs.		9b. IF UNDER 1 YEAR Months 11 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress for an Interior Decorator		10b. KIND OF BUSINESS OR INDUSTRY BEANS COVE, PENNA.	
11. BIRTHPLACE (County & State, or foreign country) U.S.S.		12. CITIZEN OF WHAT COUNTRY? U.S.S.	
13. FATHER'S NAME ALBERT SOMERLOTT		14. MOTHER'S MAIDEN NAME BLANCHE ELLIOTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-22-2718	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung & metastases to spine, lungs, Conditions, if any, which gave rise to immediate cause (b) 163 X (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1962 to 2/11/62 , that (I) (we) last saw the deceased alive on 2/11/62 , and that death occurred at 9:15 PM from the causes and on the date stated above.			
22a. SIGNATURE S. G. Weisman		22b. DATE SIGNED 2/13/62	
22c. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/62	
23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town or county) (State) Near Centerville Penna	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR FEB 15 '62	
Cumberland Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	



01337

01337

ALL-GAY BIRMINGHAM

21 DAYS

RECEIVED HOSPITAL
1200 CHAL & W. BUCK W.

RECEIVED

RECEIVED

RECEIVED

WHITE

RECEIVED

RECEIVED

RECEIVED

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
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VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01375
CERTIFICATE OF DEATH
01358

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 82 CUMBERLAND		d. STREET ADDRESS 1 23 W. ROBERTS ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If paid hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HOMER GUY BICE				4. DATE OF DEATH Month Day Year FEBRUARY 6, 19 62			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-1900		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist Helper Railroad		10b. KIND OF BUSINESS OR INDUSTRY XXXXX		11. BIRTHPLACE (County & State, or foreign country) Omaha, Neb.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME LERROY BICE				14. MOTHER'S MAIDEN NAME DELLA ROY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes War II		16. SOCIAL SECURITY NO. 705-10-3640		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 592X IMMEDIATE CAUSE (a) Chronic Uremia Chronic Nephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Artery Disease Severe				INTERVAL BETWEEN ONSET AND DEATH 5 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md		20f. CITY or town (County) (State) Ally Md	
21. I certify that (I) (this hospital) attended the deceased from 2/5/62 19 to 2/6/62 19, that (I) (we) last saw the deceased alive on 2/6/62 19, and that death occurred at 1:35 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. R. J. Williams				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/7/62	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS				22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 9, 1962		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		23d. LOCATION (City, town or county) (State) Hyndman, Penna.	
24 FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE FEB 14 '62	
						25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

More...

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CHARTERED BY THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01376

CERTIFICATE OF DEATH

01359

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 26 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.,			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY XXX MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE # 1 RIDGELEY WEST VIRGINIA d. STREET ADDRESS 85X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEONARD Middle OLIVER Last BOONE			4. DATE OF DEATH Month FEBRUARY Day 25 Year 19 62			
5. SEX MALE WHITE WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			6. DATE OF BIRTH SEPT. 10, 1905 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper			10b. KIND OF BUSINESS OR INDUSTRY B. & O. W Rwy.			
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JOHN I. BOONE			14. MOTHER'S MAIDEN NAME DAVY, MARY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 705-05-5327			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X DUE TO Carcinoma of Lung with Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). INTERVAL BETWEEN ONSET AND DEATH 1 yr						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 61 to Feb 62, 1962, that (I) (we) last saw the deceased alive on Feb 25, 1962, and that death occurred at 9:05 P.M. from the causes and on the date stated above.						
22a. SIGNATURE DR. OVERTON HIMMELWRIGHT			22b. DATE SIGNED 2/27/62			
22c. PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT			22d. ADDRESS 133 VIRGINIA AVENUE, CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/28/62		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		
23d. LOCATION (City, town or county) Near Cumberland, Md.		(State)				
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			25a. REC'D BY REGISTRAR DATE MAR 1 '62			
ADDRESS Cumberland, Md.			25b. REGISTRAR'S SIGNATURE Charles L. George			

01888

01888



WEST VIRGINIA
ROUTE 2, 1 RIDGELEY WEST VIRGINIA

22 DAYS
CONCERNED

WARRICK & HENRI
AVES.,
GENERAL HOSPITAL

RECEIVED
JANUARY 22

WHITE
SETTLED

U.S.A. WEST VIRGINIA

DAVEY, HARRY
JOHN I. COLE

GENERAL HOSPITAL, CHESTER, MARYLAND

DR. CAVES, HENRI WRIGHT
173 VIRGINIA AVE., CHESTER, MD.

DR. CAVES, HENRI WRIGHT
173 VIRGINIA AVE., CHESTER, MD.

DR. CAVES, HENRI WRIGHT
173 VIRGINIA AVE., CHESTER, MD.

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01377
01860
CERTIFICATE OF DEATH
Item 9 Film G307 2/15/62 iwk

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 02 CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 17 Euclid Place	
3. NAME OF DECEASED (Type or print) First Middle Last DAVID LAWRENCE BRATLER		4. DATE OF DEATH Month Day Year 2 8 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/09
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Baking Co.	9. AGE (In years last birthday) 52 yrs.
13. FATHER'S NAME Augustine Bratler		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes WWII		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. WW II		14. MOTHER'S MAIDEN NAME MARY ANN PENLEBERRY	
17. INFORMANT CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic pneumonia, Cardiac decompensation, Embolus		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to 2/1/62 , that (I) (we) last saw the deceased alive on 2/1/62 , and that death occurred at 9:30 AM from the causes and on the date stated above.			
22a. SIGNATURE William P James		22b. DATE SIGNED 2/14/62	
22c. PHYSICIAN'S NAME (Type) DR. JAMES		22d. ADDRESS 441 N CENTRE STREET	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/13/62	
23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.		23d. LOCATION (City, town or county) (State) Mt. Savage Md	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md		25a. REC'D BY REGISTRAR DATE FEB 13 '62	
25b. REGISTRAR'S SIGNATURE John J. Frank			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 101361
01378
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland, c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 115 So. Allegany St.,		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 Cumberland, d. STREET ADDRESS 115 So. Allegany St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Hazel Last Carder		4. DATE OF DEATH Month Feb. Day 17, Year 19 62	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 14, 1902	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Apt. Bldg.	
11. BIRTHPLACE (County & State, or foreign country) Halltown, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles W. Brown		14. MOTHER'S MAIDEN NAME Fannie Bell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No, (If yes give year or dates of service)		17. INFORMANT Address Cumb. Md. Mrs. Morris L. Barnes 115 So. Allegany St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Coronary artery disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-18-62 to 2-17-62 that (I) (we) last saw the deceased alive on 2-9-62 and that death occurred at 11:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W. F. Williams M.D.		22b. DATE SIGNED 2/19/62	
22c. PHYSICIAN'S NAME (Type) W. F. Williams M.D.		22d. ADDRESS 122 So. Centre St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/20/62	
23c. NAME OF CEMETERY OR CREMATORY Grace Episcopal Cem.		23d. LOCATION (City, town or county) (State) Elkridge, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		25a. REC'D BY REGISTRAR FEB 21 '62	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

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Handwritten notes and stamps, including "M" and "1" in circles, and various illegible markings.

Handwritten signature or name, possibly "George" or "Gordon".

1-18-64 2-11-64

Handwritten notes and stamps, including "M" and "1" in circles, and various illegible markings.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01379 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01362

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cresaptown,			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D. O. A. Memorial Hosp.				d. STREET ADDRESS 101 Brant Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OSCAR Middle HENRY Last CECIL				4. DATE OF DEATH Month Feb. Day 24 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1903		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 24 Days 19	IF UNDER 24 HRS. Hours 24 Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager,		10b. KIND OF BUSINESS OR INDUSTRY Packing House		11. BIRTHPLACE (State or foreign country) Cresaptown, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. Cecil				14. MOTHER'S MAIDEN NAME Susan Alexander			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No,		16. SOCIAL SECURITY NO.		17. INFORMANT Address Md. town, Mrs. Ada R. Cecil 101 Brant Rd. Cresap-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO CORONARY SCLEROSIS INTERVAL BETWEEN ONSET AND DEATH SUDDEN -----						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DATE SIGNED February 24, 1962			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/27/62		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
23. FUNERAL DIRECTOR Charles L. George				22d. LOCATION (City, town, or county) Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE FEB 28 '62	
ADDRESS Cumberland, Md.				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01380

CERTIFICATE OF DEATH

01363

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1yr; lmo., 3das.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 400 Grand Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edna Middle Chadwick Last Chadwick		4. DATE OF DEATH Month Feb. Day 23 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1880
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Department Store	
11. BIRTHPLACE (State or foreign country) Keyser W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jeremiah Chadwick		14. MOTHER'S MAIDEN NAME Barbara Roades	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Floyd Chadwick Wyckoff, N.J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Breast, bilateral, operated 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis Rt. Cervical gland & lymph DUE TO (c) General metastasis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 17:11 Severe myocardial infarction & pulmonary reaction			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 19 61 , to Feb. 23, 19 62 , that I last saw the deceased alive on Feb. 23, 19 62 , and that death occurred at 2:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene Street, Cumberland, Md. DATE SIGNED 2/24/62			
ACTUAL SIGNATURE L. B. Mathews, M.D.		M.D. 49 Greene Street, Cumberland, Md.	
PHYSICIAN'S NAME (Type) L. B. Mathews, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-26-62	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE FEB 27 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

01383

CERTIFICATE OF DEATH

01383



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01381
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Midland		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Paradise Street		d. STREET ADDRESS Paradise Street	
3. NAME OF DECEASED (Type or print) First Isabella Middle Ross Last Glise		4. DATE OF DEATH Month 2 Day 1 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/11/1887
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 1 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Salem Ross		14. MOTHER'S MAIDEN NAME Mary Ellen Dye	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Thomas F. Clise		Address Midland, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis + Hypertension (c) Antenatal PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) (Husband) 5 weeks years		INTERVAL BETWEEN ONSET AND DEATH 5 weeks years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 27, 1956 to Feb. 1, 1962 that (I) (we) last saw the deceased alive on Jan 30, 1962 , and that death occurred at 9 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Leslie R. Miles, Jr., M.D.		22b. DATE SIGNED 2-1-62	
22c. PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D.		22d. ADDRESS Lonaconing, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/1962	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town or county) (State) Frostburg, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		25a. REC'D BY REGISTRAR FEB 5 '62	
ADDRESS LONA CONING, MD.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01382

CERTIFICATE OF DEATH

01865

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in lb 54 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 146 FREDERICK STREET	
3. NAME OF DECEASED (Type or print) CARL W CORRICK		4. DATE OF DEATH Month 2 Day 9 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICAL APPLIANCE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME EDWARD CORRICK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		14. MOTHER'S MAIDEN NAME LUELLA	
17. INFORMANT CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circumference of Colon with generalized perforations Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 153.8 DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1962 to July 9, 1962 and that (I) (we) last saw the deceased alive on July 9, 1962 and that death occurred at 4:15 P.M. from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE B. Schindler 22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22b. DATE SIGNED 2/14/62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 43 GREENE STREET	
23a. BURIAL, CREMATION, REMOVAL* (Specify) Burial	23b. DATE THEREOF 2/13/62	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.	23d. LOCATION (City, town or county) (State) Cumberland Md.
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. ADDRESS Cumbr. Md.		25a. REC'D BY REGISTRAR DATE FEB 13 '62 25b. REGISTRAR'S SIGNATURE William S. Hume	

01582



[Faint, illegible handwritten text, possibly a signature or address, spanning the bottom half of the page.]

VS. A15ME
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CHURCHILL, JAMES

CHURCHILL, JAMES

CHURCHILL, JAMES

CHURCHILL, JAMES

CHURCHILL, JAMES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01384
CERTIFICATE OF DEATH
01367

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 21 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE d. STREET ADDRESS 1 a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES CUNNINGHAM		4. DATE OF DEATH Month Feb. Day 12 Year 1962					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 28, 1893	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - MT. SAVAGE REFRACTORY		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PA.			
13. FATHER'S NAME John Thomas Cunningham		14. MOTHER'S MAIDEN NAME Nora Kelley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-0846		17. INFORMANT PATIENTS CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of hepatic flexure of colon 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 6 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 2-6- to 2-12- , 19 62 , that (I) (we) last saw the deceased alive on 2-11- 19 62 , and that death occurred at 2:06 AM from the causes and on the date stated above.							
22a. SIGNATURE Lewis Brings		M.D. LEWIS BRINGS, M.D.		22b. DATE SIGNED 2-12-62			
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/15/62	23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery	23d. LOCATION (City, town or county) (State) Mt. Savage, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Harvey A. Leigler		ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR FEB 16 '62			
				25b. REGISTRAR'S SIGNATURE Arthur L. Kinnear			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01385

01368

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport c. LENGTH OF STAY IN b 18 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 119 Wood St.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport d. STREET ADDRESS 119 Wood St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Robinson Last Davis		4. DATE OF DEATH Month Feb. Day 10 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 1, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery Stote	
11. PLACE OF BIRTH (County & State, or foreign country) Mineral W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jonathan W.W. Davis		14. MOTHER'S MAIDEN NAME Florence I. Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Elton Gurley-Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 480X DUE TO Influenza Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) chronic Myocarditis (c) chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 1 Day 3 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 10, 1961 to Feb 10, 1962 , that (I) (we) last saw the deceased alive on Feb 10, 1962 , and that death occurred at 11:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson M.D.		22b. DATE SIGNED Feb 12, 1962	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson		22d. ADDRESS Piedmont, W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/14/62	
23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. Beral		25a. REC'D BY REGISTRAR DATE FEB 14 '62	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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Division - Finance
In...

Change in...

For 12-1-13
D. G. Miller



Postmaster, No.

Ed. B. B. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01386					01369									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)									
a. COUNTY		ALLEGANY			a. STATE		MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CUMBERLAND			b. COUNTY		ALLEGANY							
c. LENGTH OF STAY in 1b		30 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		02 CUMBERLAND							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
SACRED HEART					1 983 MC MULLEN HIGHWAY									
3. NAME OF DECEASED					4. DATE OF DEATH									
(Type or print)		First Middle Last			Date of Death		Month Day Year							
MARY		ADA			DAVIS		FEB.		28 19 62					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.						
FEMALE		WHITE				MARCH 2, 1882		79						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
HOUSEWIFE							MARYLAND		U.S.A.					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
FRED GORTNER (DECEASED)					LYDIA BEACHY									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
No										DAUGHTER: MILDRED DAVIS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-62 DUE TO Myocardial Infarction														
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerosis Heart Disease										unk				
(c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.					20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19														
21. I certify that (I) (this hospital) attended the deceased from Aug 1961, to 28 Feb., 1962, that (I) (we) last saw the deceased alive on 26 Jan. 1962 and that death occurred at M, from the causes and on the date stated above.														
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED				
L. Michael Glick					M.D.					2/28/62				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS									
L. MICHAEL Glick					126 N. SMALLWOOD CUMBERLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)						
Burial			3/2/62		HILLCREST BURIAL PARK			Cumberland, Maryland						
24 FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
John J. Hafer					230 Baltimore Ave. Cumberland, Maryland					DATE MAR 5 '62				
										C. S. Kraw				

01333

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01387

CERTIFICATE OF DEATH

013870

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY in 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02126 Fredrick St. Cumberland, Md. d. STREET ADDRESS 126 Fredrick St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Naomi I. Davis			4. DATE OF DEATH Feb. II 1962		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 13, 1896		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maids		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (County & State, or foreign country) Maryland, Cumberland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Stephen Davis		14. MOTHER'S MAIDEN NAME Ida Pyper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Pt.'s chart Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570 - Intestinal obstruction DUE TO (b) Mesenteric Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Atherosclerosis + Hypertensive Cardiovascular Disease					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from October 26, 1961 to Feb. 11, 1962 ; that (I) (we) last saw the deceased alive on 2/11/62 , and that death occurred at 4:20 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Dr. Weisman		22b. DATE SIGNED 2/13/62		22c. PHYSICIAN'S NAME (Type) Dr. Weisman	
22d. ADDRESS 59 Greenest Cumberland, Md		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/15/62		23c. NAME OF CEMETERY OR CREMATORY Emmanuel Meth. Cem.	
23d. LOCATION (City, town or county) Cumberland Md		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb-Md		24a. ADDRESS		24b. REC'D BY REGISTRAR FEB 19 '62	
24c. REGISTRAR'S SIGNATURE Arthur L. Thomas		24d. DATE			

01070

01070



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 9 HRS. 25 MIN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE, MARYLAND d. STREET ADDRESS 6 NATIONAL HIGHWAY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) MARSHALL J. DEREMER					4. DATE OF DEATH Month FEBRUARY Day 1 Year 19 62									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 1, 1907		9. AGE (In years last birthday) 54 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10b. KIND OF BUSINESS OR INDUSTRY MONARCH PRINTING CO. CUMBERLAND, MARYLAND		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME RANDOLPH DEREMER					14. MOTHER'S MAIDEN NAME MAUDE E. BANE									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO. 214-05-5331					17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible acute cerebro-vascular hemorrhage. 420. } DUE TO Chronic C.S.P. with Hypertension Conditions, if any, which } (b) Chronic Coronary Artery Disease. gave rise to immediate cause (a), stating the underlying } DUE TO cause last. } (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH approx 20 hrs.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from approx 1962 to 1962 , that (I) (we) last saw the deceased alive on 2-1-1962 , and that death occurred at 11:40 P.M. from the causes and on the date stated above.														
22a. SIGNATURE John A. Topper M.D. 22c. PHYSICIAN'S NAME (Type) DR. JOHN TOPPER					22b. DATE SIGNED 2-5-62 22d. ADDRESS HYNDMAN, PA.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/4/62		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Burial Park		23d. LOCATION (City, town or county) (State) near Cumberland, Maryland								
24 FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland ADDRESS					25a. REC'D BY REGISTRAR FEB 5 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

01371

CERTIFICATE OF DEATH

01388



CLAMBERLAND
2 WIS. ST. WIS. 1901
NATIONAL HIGHWAY

PRINTER
MONARCH PRINTING CO. CLAMBERLAND, WIS. 1901
J. DORNER
MARCH 1, 1901

BARBOLPH DEGENER
CLAMBERLAND HOSPITAL - CLAMBERLAND, WIS. 1901

DR. JOHN T. ...
WIS. 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
01389 CERTIFICATE OF DEATH 01372															
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN IT 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 121 HUMBIRD STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) James E. Dyche						4. DATE OF DEATH Month FEB. Day 12 Year 1962									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 31, 1894		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist				10b. KIND OF BUSINESS OR INDUSTRY Railroad				11. BIRTHPLACE (County & State, or foreign country) MAGNOLIA, W. VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES H. DYCHE						14. MOTHER'S MAIDEN NAME JANE REXRODE									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 705-09-9455		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis 446X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Papillary carcinoma bladder (under control) INTERVAL BETWEEN ONSET AND DEATH															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 2-5-62 , 19 62 , to 2-12-62 , 19 62 that (I) (we) last saw the deceased alive on 2-12-62 , 19 62 and that death occurred at 12:15 PM from the causes and on the date stated above.															
22a. SIGNATURE Howard K. Tolson						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) Howard K. Tolson						22d. ADDRESS 1725 Center St. Cumberland, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb. 15, 1962		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery				23d. LOCATION (City, town or county) (State) Cumberland, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.						ADDRESS		25a. REC'D BY REGISTRAR FEB 15 '62		25b. REGISTRAR'S SIGNATURE James F. Scarpelli					

M

01320

01372

ALLEGANY

WARTLAND

WARTLAND

CUMBERLAND

CUMBERLAND

WAYS

MEMORIAL HOSPITAL

121 LAMBERT STREET

JAMES H. DYCKE

JAMES H. DYCKE

no

121-00-000 MEMORIAL HOSPITAL

CUMBERLAND, MD.

James P. Scarpell, Cumberland, Md.

Serial

121-00-000 Memorial Hospital, Cumberland, Md.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01390

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01373

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 02 Cumberland			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital D.O.A.				d. STREET ADDRESS 318 Beall St.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Blanche		First Amy		Middle Hager		Last	
4. DATE OF DEATH Feb. 8, 1962		Month		Day		Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1899	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Fayette Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Solomon				14. MOTHER'S MAIDEN NAME Susan King			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Joseph Hager		Address 318 Beall St., Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420 DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS						INTERVAL BETWEEN ONSET AND DEATH SUDDEN ---	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) R. 9, Cumberland, Md.							
ACTUAL SIGNATURE Benedict Skitarelic		M.D. BENEDICT SKITARELIC, M.D.		DATE SIGNED February 8, 1962			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11, 1962		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial	
23. FUNERAL DIRECTOR Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR FEB 13 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

01330

01330

1
MAY 1961



Handwritten signature or name.

Handwritten text, possibly a date or location.

Handwritten text, possibly a date or location.

Handwritten text, possibly a date or location.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01391 CERTIFICATE OF DEATH 01374

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 221 N. Lee St.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02 d. STREET ADDRESS 221 N. Lee St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna First E. Middle Heller Last		4. DATE OF DEATH Feb. 10, Month 1962 Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1878
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Louis H. Fredericks	
14. MOTHER'S MAIDEN NAME Mary Anna Stewart		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. MISS MILDRED M. HELLER		17. INFORMANT 221 N. Lee St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 1 year (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1960 to 6 Feb. 1962 , that (I) was last saw the deceased alive on 6 Feb. 1962 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE L. Michael Glick M.D.		22b. DATE SIGNED 10 Feb 62	
22c. PHYSICIAN'S NAME (Type) L. Michael Glick		22d. ADDRESS 126 N. Smallwood St. Cumberland, Md.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE 2/13/62	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem		23d. LOCATION (City, town or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		25a. REC'D BY REGISTRAR DATE 13 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thorne			

01391

01391



Allegany

Quincy

221 N. 1st St.

Anna

Female White

Domestic

Charles

John H. Erickson

221 N. 1st St.

John H. Erickson

John H. Erickson

Domestic, White

221 N. 1st St.

Anna

221 N. 1st St.

221 N. 1st St.

John H. Erickson

221 N. 1st St.

John H. Erickson

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01392 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01375

1. PLACE OF DEATH e. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 82 Cumberland		d. STREET ADDRESS 1 624 Greene St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 624 Greene St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Smith Helman				4. DATE OF DEATH Month February Day 6 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1884		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Schmidt Bakery		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph F. Helman				14. MOTHER'S MAIDEN NAME Elizabeth Alsip			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Maude S. Helman, Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION, LEFT DUE TO 420 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) CORONARY SCLEROSIS WITH THROMBOSIS (c) 						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. Month, Day, Year 19 p.m. 		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 6, 1962 DATE SIGNED Address (Street, city, town, or county) R9 Cumberland, Md.							
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/62		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR Louis Stein				ADDRESS 117 Frederick St., Cumb. Md.		24e. REC'D BY REGISTRAR DATE FEB 8 '62	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

01852

2882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01393

01376

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 70 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 1 1011 Grant St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Eliza Houseworth				4. DATE OF DEATH Feb. 5 1962		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1884 77		9. AGE (In years last birthday) 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Harpers Ferry, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cyrus H. Fisher				14. MOTHER'S MAIDEN NAME Laura V. Barger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Howard Fisher, Cumberland, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombotic Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arteriosclerosis (c) 5 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 5 1962 to Feb 5 1962 that (I) (we) last saw the deceased alive on Feb 5 1962 and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Clay E. Durrett M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/5/62	
22c. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, MD				22d. ADDRESS 236 Virginia Ave. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 8, 1962		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR FEB 13 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

2000

2010

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained to your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01394 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01377											
1. PLACE OF DEATH a. COUNTY Allegany. MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE W.Va. b. COUNTY Mineral					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Maryland.						c. LENGTH OF STAY IN 1b Short Gap.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital.						d. STREET ADDRESS 85X-3					
3. NAME OF DECEASED (Type or print) First CATHERYN Middle HUTTON Last HUTTON						4. DATE OF DEATH Month 2 Day 8 Year 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 -25 -1897		9. AGE (In years last birthday) 64		10. IF UNDER 1 YEAR Months 64 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Williamsport , Pa.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WARREN STOUCK.						14. MOTHER'S MAIDEN NAME MARY ALICE Gilmore.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.				16. SOCIAL SECURITY NO. 185-09-3887.		17. INFORMANT Address Mr. Cyrus Calvin Hutton. Short Gap, W.Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION											
DUO TO CORONARY SCLEROSIS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
HYPERTENSIVE CARDIOVASCULAR DISEASE											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried.						22b. DATE THEREOF 2/11/62		22c. NAME OF CEMETERY OR CREMATORY Lahmansville Cemotery.		22d. LOCATION (City, town, or country) (State) Lahmansville, W.Va.	
23. FUNERAL DIRECTOR J.Blaine Schaeffer.						ADDRESS Petersburg, W.Va.		24e. REC'D BY REGISTRAR FEB 13 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

01377

1334

EX 311



Allegany,

Cumberland, Maryland,

Memorial Hospital,

Short Gate,

NOTION

CATON

5 - 6 - 62

12-25-1937

Yonkers White

House Wife,

Williamport, Pa., U.S.A.

WARREN STODOL,

MARY ALICE OLIMORE,

185-00-3887, Mr. Eugene Calvin Nelson, Short Gate, W. Va.

No.

dated 2/11/38, Indianapolis, Ind., Va.

Edwina Schaeffer, Petersburg, Va.

1
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

01395

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01378

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (if outside corporate limits, write RURAL and nearest town) Rural Shaft Frostburg		c. LENGTH OF STAY IN 1b Shaft			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS Rural Frostburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) William T Hyde			4. DATE OF DEATH Month February Day 15 Year 1962		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1888	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Barton, Maryland	
13. FATHER'S NAME Fred Hyde			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			14. MOTHER'S MAIDEN NAME Mary Sugars		
16. SOCIAL SECURITY NO. No			17. INFORMANT Sherman Hyde Lonaconing, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation 974-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Asphyxiation (c) Asphyxiation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Hung Self from Ladder with Dog Chain					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Hung Self from Ladder with Dog Chain			
20c. TIME OF INJURY Hour 8:00 a.m. Feb 15 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) mine building Shaft Allegany Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W O McLane M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) W O McLane MD DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county) Frostburg Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/62		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	
22d. LOCATION (City, town, or country) Moscow, Md.		22e. REC'D BY REGISTRAR DATE FEB 19 '62			
23. FUNERAL DIRECTOR George Eichhorn		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna			

01378

01382



Allegany

Harland

Spirt

Allegany

Harland

Spirt

Harland

Spirt

February 13 1902

Hyde

T

William

79

August 30, 1880

1

White

Male

U.S.A.

Harland, Maryland

Coal Mine

Settled when

Many years

Trod Hyde

Lennoxville, N.Y.

Sherrin Hyde

"30"

Id.

Moscow,

Lennoxville, N.Y.

2/12/02

Burial

Lennoxville, N.Y.

George Richmond

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01396 CERTIFICATE OF DEATH 01379											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 HRS. 34 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARNICK AVES. MEMORIAL HOSPITAL						d. STREET ADDRESS 513 FREDERICK STREET					
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last JACOBS						4. DATE OF DEATH Month FEB. Day 13 Year 19 62					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-13-62		9. AGE (In years last birthday) yrs. 8 Months 34		IF UNDER 1 YEAR Months 8 Days 34	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LEWIS F. JACOBS						14. MOTHER'S MAIDEN NAME SANDRA LEE BROWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 7-1-5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Premature rupture membranes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 3 Wks											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Feb 13 62 Feb 13 62 21. I certify that (I) (this hospital) attended the deceased from 2:40 P.M. to Feb 13 62 that (I) (we) last saw the deceased alive on Feb 13 62 and that death occurred at M , from the causes and on the date stated above. 22a. SIGNATURE W. T. Hodges M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) DR. W. ROYCE HODGES 22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-15-1962		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City, town or county) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE FEB 19 '62		25b. REGISTRAR'S SIGNATURE William L. Kneale			

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01879

CERTIFICATE OF BIRTH

01879

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WEEBANY

WEEBANY

WEEBANY

CUMBERLAND

8 MRS. J. M. M.

CUMBERLAND

CUMBERLAND & WILSON AVES.

CUMBERLAND HOSPITAL

312 FREDERICK STREET

JACOB

BOY

BABY

1-13-02

WHITE

WIFE

CUMBERLAND, MD.

CUMBERLAND, MD.

SARGENT L. BROWN

LEWIS T. JACOB

CUMBERLAND HOSPITAL - CUMBERLAND, MD.

152 S. CENTRAL ST., CUMBERLAND, MD.

DR. W. W. HOOVER

1-13-02

1-13-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01397						01380					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Allegany			Westernport			Maryland			X Gilmore-R*F*D #1 Frostburg, MD.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM?					
in auto enroute from his home to Dr.'s Office.						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
THOMAS JOHNSON						2/13 /1962					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White				8/29/1880		81		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Laborer								Lonaconing, MD.			
13. FATHER'S NAME						12. CITIZEN OF WHAT COUNTRY?					
Mose Johnson						U.S.A					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						14. MOTHER'S MAIDEN NAME					
No						Barbara Cutter					
16. SOCIAL SECURITY NO.						17. INFORMANT Address					
						Mr. John Cutter, Lonaconing, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>											
422.1 DUE TO (b) <i>Ch. Type Cor Pulmonale</i>											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <i>Coronary sclerosis</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19											
21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1961, to Feb 3, 1962, that (I) (we) last saw the deceased alive on Jan 29, 1962, and that death occurred at 11 PM, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
R.W. Reeves MD						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
R.W. Reeves						Westernport, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY			
Burial				3/5/1962				Old Coney Cemetery			
24. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				23d. LOCATION (City, town or county) (State)			
GEORGE EICHHORN				LONACONING, MD.				Lonaconing, MD.			
25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				DATE			
FEB 7 '62				Arthur L. Kram							

0210

52210

1992

COVERS 11

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01381

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained to your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 107 N. Johnson St.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 Cumberland d. STREET ADDRESS 106 Massachusetts Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) William Franklin Kerns				4. DATE OF DEATH February 23 1962													
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1908		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman (Retired)				10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad				11. BIRTHPLACE (State or foreign country) Cumberland, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Pint Kerns						14. MOTHER'S MAIDEN NAME Sarah Jane Robinson											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No						16. SOCIAL SECURITY NO. 						17. INFORMANT Address Mrs. William F. Kerns, Cumberland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (c) Coronary Sclerosis (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH Sudden					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Dr. Benedict Skitarelic						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 2/23/62 DATE SIGNED R 9 Cumberland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/26/62				22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Park				22d. LOCATION (City, town, or country) (State) Cumberland, Md.					
23. FUNERAL DIRECTOR Louis Stein Jr.						ADDRESS 117 Frederick St. Cumb., Md.						24a. REC'D BY REGISTRAR DATE FEB 28 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01399

CERTIFICATE OF DEATH

01382

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 22 Frostburg, M	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital, Frostburg, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Casper Middle E Last Kight		4. DATE OF DEATH Month Feb. Day 23 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1875
9. AGE (In years lost birthday) yrs. 86		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Store owner		10b. KIND OF BUSINESS OR INDUSTRY own- retired	
11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Josh Kight		14. MOTHER'S MAIDEN NAME Eliza Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-01- 8675	
17. INFORMANT Theodora Kight Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 yrs.?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) XXXX		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) XXXX	
20c. TIME OF INJURY Month, Day, Year Hour o. m. XXXX 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) XXXX		20f. (City or town) (County) (State) XXXX	
21. I certify that (I) (this hospital) attended the deceased from Feb. 2 19 62 , to Feb. 23 19 62 , that (I) (we) last saw the deceased alive on Feb. 23 19 62 , and that death occurred at 7:25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein M.D.		22b. DATE SIGNED 2/23/62	
22c. PHYSICIAN'S NAME (Type) Martin M. Rothstein M.D.		22d. ADDRESS 48 Broadway, Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/26/62	
23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION (City, town, or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. Fredlock Jr.		25a. REC'D BY REGISTRAR DATE FEB 26 '62	
ADDRESS Piedmont, W.Va.		25b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01400

01383

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE 2		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG d. STREET ADDRESS ROUTE 2 - CONSOLIDATION e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle G. Last LEWIS		4. DATE OF DEATH Month FEBRUARY Day 16 , Year 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 10, 1901
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DAVID G. LEWIS	
14. MOTHER'S MAIDEN NAME MARTHA JONES		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 214-05-9859	
16. SOCIAL SECURITY NO. 214-05-9859		17. INFORMANT Address MRS. EMMA LEWIS, FROSTBURG, MD. BOX 58	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 1 year			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-2- 1962 , to 2-16- 1962 , that (I) (we) last saw the deceased alive on 2-4- 1962 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Lewis Brings M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M. D.		22d. ADDRESS 57 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB. 18 '62	23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK	23d. LOCATION (City, town or county) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Ours ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE FEB 19 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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PORT OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01401

CERTIFICATE OF DEATH

Reg. Dist. No. 01384

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	c. LENGTH OF STAY IN 1b <u>4 mos. 4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sylvan Retreat</u>		d. STREET ADDRESS <u>125 N. Centre Street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u></u> Last <u>Lowdermilk</u>		4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/29/95</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interstate Commerce Inspector - B & O Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd Lowdermilk</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Riley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-09-9855</u>	
17. INFORMANT <u>Mrs Leroy Lowdermilk - Cumberland, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis, Ch. degenerative</u> DUE TO <u>Virus Infection, Respiratory</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>17:11 Suicide, Psychotic Reaction</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>Oct. 5, 1961</u> to <u>Feb. 9, 1962</u> , that I last saw the deceased alive on <u>Feb. 9, 1962</u> , and that death occurred at <u>4:02 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>L. B. Mathews, M.D.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>L. B. Mathews, M.D.</u>		<u>49 Greene St., Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/12/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Addison Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Addison Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer Cumberland Md.</u>		24a. REC'D BY REGISTRAR DATE <u>EB 14 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

CERTIFICATE OF DEATH

State of Maryland, Department of Health - Baltimore

County of Baltimore

City of Baltimore

DECEASED
 NAME
 BORN
 DIED

U.S.A.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
 DATE 01-11-2001 BY 60322 UCBAW/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01402					01385									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY ALLEGANY					a. STATE MARYLAND									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					b. COUNTY ALLEGANY									
c. LENGTH OF STAY IN 1b 6 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 11 ALTAMONT TERRACE									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last DAVID THOMAS MARTIN					Month Day Year FEBRUARY 10 19 62									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-2-62		9. AGE (In years last birthday) 8 DAYS						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Infant)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME JOHN ROBERT MARTIN					14. MOTHER'S MAIDEN NAME MARY NAIRN									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. None					17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Failure of Respiratory System 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) Intestinal obstruction (c) DUE TO Malrotation and midgut volvulus cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....9:00 AM....., from the causes and on the date stated above.														
22a. SIGNATURE Robert H Brodell					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/11/62			
22c. PHYSICIAN'S NAME (Type) DR. ROBERT BRODELL					22d. ADDRESS 129 S. LIBERTY ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/12/62		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.			23d. LOCATION (City, town or county) (State) Cumberland, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.					25a. REC'D BY REGISTRAR FEB 13 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas							

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Charles L. George, Charleston, S.C.

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STATE OF MARYLAND 01403 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01386**

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural of Cumberland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Sacred Heart Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural of Cumberland</u> X d. STREET ADDRESS <u>Cresaptown, Maryland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Patrick McCusker</u>			4. DATE OF DEATH Month Day Year <u>February 1 19 62</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/1903</u>	9. AGE (In years last birthday) <u>58 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Peoples Transit Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>William Oliver McCusker</u>				
14. MOTHER'S MAIDEN NAME <u>Carrie Jenetta Grant</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>214-07-6940</u>		17. INFORMANT Address <u>Elizabeth Richardson McCusker, Cresaptown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u> (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Feb. 1, 1962</u>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>R9, Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/4/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>			
22d. LOCATION (City, town, or county) <u>Cumberland, Maryland</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>			24a. REC'D BY REGISTRAR DATE <u>FEB 5 '62</u>				
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01404										
CERTIFICATE OF DEATH										
01387										
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lonaconing					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lonaconing					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS 1					
3. NAME OF DECEASED (Type or print) George McManus					4. DATE OF DEATH February 9 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1879		9. AGE (In years last birthday) 82 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (County & State, or foreign country) Barton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Thomas McManus					14. MOTHER'S MAIDEN NAME McCutcheon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no					16. SOCIAL SECURITY NO. William A. Green					17. INFORMANT Lonaconing, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 422.2 IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 5 Years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1961 to Feb. 9, 1962 that (I) (we) last saw the deceased alive on Feb. 2, 1962 , and that death occurred at 11:30 AM , from the causes and on the date stated above.										
22a. SIGNATURE Paul R. Wilson M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED Feb 10 1962					
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.					22d. ADDRESS Piedmont, W. Va.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/12/62		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town or county) (State) Lonaconing, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn					ADDRESS Lonaconing, Md.					
25a. REC'D BY REGISTRAR Feb 13 '62					25b. REGISTRAR'S SIGNATURE William S. Thomas					

(M)

01404

01387

Allegany

Maryland

Allegany

Longmont

Longmont

George

William

February 9

Male

White

March 1, 1879

82

Retired Miner

Coal Mine

Barton, Maryland

U.S.A.

Thomas McNamee

McNamee

no

William A. Green

Longmont, Md.

George Richmond

Oak Hill Cemetery

Longmont, Md.

Longmont, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Items 21 & 4

CERTIFICATE OF DEATH Film G309

01388

1. PLACE OF DEATH e. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 1 Wk.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Grahamtown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital		d. STREET ADDRESS 77 Armstrong St.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest Monsen		4. DATE OF DEATH 2 14 15 1962		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-26-1883	
9. AGE (In years last birthday) 78 79/ yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Oslo, Norway	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Katherine G. Iffin, Sister-in-law	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-0 DUE TO Cirrhosis of liver Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO Arteriosclerotic Cardiac disease		INTERVAL BETWEEN ONSET AND DEATH weeks years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 11/11 1961		20g. (County) 2/15/14 1962		20h. (State) 1962	
21. I certify that (I) (this hospital) attended the deceased from 11/11 1961 to 2/15/14 1962 , that (I) (we) last saw the deceased alive on 2/15 14 1962 , and that death occurred at 2:15 PM , from the causes and on the date stated above.					
22a. SIGNATURE J.B. Davis		22b. DATE SIGNED 2/16/62		22c. PHYSICIAN'S NAME (Type) John B. Davis, MD	
22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-18-62		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery Frostburg, Md.	
23d. LOCATION (City, town or county) Frostburg, Md.		23e. REC'D BY REGISTRAR DATE FEB 20 '62			
24. FUNERAL DIRECTOR'S SIGNATURE Pearl H. Mattingly		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

01388

Allegany

MD.

Greenbush

1. W.

77 Ar. 1900

2 12 12

2-2-1900

U. S. A.

Ohio, Wayne

Railroad

Machine

Unborn

Unborn

None

None

None

Unborn of the
Unborn of the

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2-2-1900

2-2-1900

2-2-1900

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. AISM
SM 9/60

FOR STATE
HEALTH DEPT.

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3
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01406 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01389

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 53 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 82 Cumberland		d. STREET ADDRESS 311 Broadway			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. Sacred Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First John Middle B. Last Morris				4. DATE OF DEATH Month Feb. Day 2 Year 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 18, 1908			
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 53		IF UNDER 24 HRS. Hours 53 Min. 53					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car Inspector Railroad				10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William W. Morris				14. MOTHER'S MAIDEN NAME Julia F. Ryan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 705-96-9674					
17. INFORMANT James E. Morris, Cumberland, Md.				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. Month, Day, Year 19 p.m.		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Benedict Skitarelic, MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				Address (Street, city, town, or county) R 9 Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/62		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR James F. Scarpelli Cumberland, Md.				24a. REC'D BY REGISTRAR FEB 6 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
				DATE					

01220

01108

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01407

01390

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If deceased died in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 931 GAY ST.	
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last MULLENAX		4. DATE OF DEATH Month FEB. Day 17 Year 19 62	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-62
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR Months 10 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM MULLENAX		14. MOTHER'S MAIDEN NAME CATHERINE DEMPSIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) Prematurity (c) DUE TO cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3:45 P.M. , 19 62 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE Robert D. Brodell M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. ROBERT D. BRODELL		22d. ADDRESS 129 S. LIBERTY ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-17-62	
23c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Smith		25a. REC'D BY REGISTRAR DATE FEB 26 '62	
ADDRESS 1000395011		25b. REGISTRAR'S SIGNATURE Robert L. Smith	



01107

01100

ALLEGANY

WHEELING

WHEELING

ALLEGANY

COUNSELING

Y. H. P. DIV.

COUNSELING

HOSPITAL & WARHOUSES

321 DIV ST.

HOSPITAL

FEB. 11

WHEELING

GIRL

BOY

WHITE

2-1-80

COUNSELING

WILLIAM MILLER

CATHERINE DELPHE

HOSPITAL - COUNSELING

152 S. LIBERTY ST., COUNSELING

DR. WOOD 2. E. E. E. E.

Handwritten signature: Charles E. E. E.

12 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01408

CERTIFICATE OF DEATH

01391

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN b. 55 MINUTES			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL				d. STREET ADDRESS 419 BEALL ST.			
3. NAME OF DECEASED (Type or print) JOHN PEDDER				4. DATE OF DEATH FEB. 15, 1962			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-17-1891 1877	
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chg. of Bleach Plt. Paper Industry				10b. KIND OF BUSINESS OR INDUSTRY ENGLAND, Widnes			
11. BIRTHPLACE (County & State, or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JAMES PEDDER				14. MOTHER'S MAIDEN NAME SARAH Summersgill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.				16. SOCIAL SECURITY NO. 109-01-4649			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma DUE TO Cirrhosis of Liver Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 581.0 (c)				INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9 - 6 9:35 P.M. to 2 - 15 , 19 62 that (I) (we) last saw the deceased alive on 2 - 15 , 19 62 , and that death occurred at 9:35 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Ralph W. Ballin M.D.				22b. DATE SIGNED 2-17-62			
22c. PHYSICIAN'S NAME (Type) DR. RALPH W. BALLIN				22d. ADDRESS 62 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/18/62		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.				25a. REC'D BY REGISTRAR FEB 20 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

01001

01409



MEMORIAL HOSPITAL
GENERAL & SURGICAL WINGS
22 MINUTES
CONFERENCED

FEB. 17, 1952

PEOPLE

WIFE

2-17-1952

WHITE

U. S. A. ENGLAND, U. S. A.

SAVANNAH, GEORGIA

JAMES T. COLE

MEMORIAL HOSPITAL - CONFERENCED

2-17-1952

2 weeks

Hepatic coma

4 weeks

Diagnosis of liver

2 - 15

2 - 15

2-17-52

x

CONFERENCED

DR. ALFRED W. BELLIN

WIFE

SAVANNAH, GEORGIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01409 Item 8 Film 0307 2/16/62 ink											
01392											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE d. STREET ADDRESS 35 RYE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN IB 21 HRS.							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL											
3. NAME OF DECEASED (Type or print) CARL				First Middle Last PETERSON				4. DATE OF DEATH Month Day Year FEBRUARY 8 19 62			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1879 MAY 31, 1880		9. AGE (In years last birthday) 82 8X yrs.		IF UNDER 1 YEAR Months Days 82 8X	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER (RET.)				10b. KIND OF BUSINESS OR INDUSTRY OWN FARM				11. BIRTHPLACE (County & State, or foreign country) SWITZERLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PETER PETERSON				14. MOTHER'S MAIDEN NAME SOPHIA HUSNED							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO				16. SOCIAL SECURITY NO. 394 01 3075				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral malacia right cerebral DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis, generalized, marked DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): None								INTERVAL BETWEEN ONSET AND DEATH 1 wk ypa			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Memorial Hospital		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred 8:35 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Lester F. Kight MD				M.D. Lester F. Kight MD				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. ADDRESS Memorial Hospital		22b. DATE SIGNED 2/8/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF FEB. 12, 1962		23c. NAME OF CEMETERY OR CREMATORY LINWOOD CEMETERY		23d. LOCATION (City, town or county) (State) DUBUQUE, IOWA			
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT				ADDRESS CUMBERLAND, MD.				25a. REC'D BY REGISTRAR DATE FEB 13 '62		25b. REGISTRAR'S SIGNATURE Lester F. Kight	



01000

01000

ALLGARY

CUMBERLAND

CHURCH HOSPITAL

CARE

WHITE

MAY 31, 1950

SWITZERLAND

PETER PETERSON

SOCHI, RUSSIA

CHURCH HOSPITAL, CHURCH ST., N.Y.

The above is a copy of the original

Handwritten signature

6:35 P.M.

Handwritten notes and signatures

Handwritten notes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01410 CERTIFICATE OF DEATH 01393

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>65 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		d. STREET ADDRESS <u>1 26 E. Roberts Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>26 E. Roberts Street</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>10</u> Year <u>1962</u>									
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Ann</u> Last <u>Poole</u>				6. DATE OF BIRTH <u>Aug. 13, 1880</u>				9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 13, 1880</u>		9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hampshire County, W. Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Silas Iser</u>						14. MOTHER'S MAIDEN NAME <u>Slemma Foltz</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Ernest Poole, Flintstone, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>(Multiple small stroke syndrome)</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of item 18.) <u> </u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10-8-54</u> , 19 <u> </u> , to <u>2-8-62</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2-10-62</u> , 19 <u> </u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>G. Overton Himmelwright, M.D.</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2-13-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. Overton Himmelwright, M.D.</u>						22d. ADDRESS <u>133 Virginia Ave. Cumberland, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 14, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>				23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>						ADDRESS <u> </u>		25a. REC'D BY REGISTRAR DATE <u>FEB 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Harris</u>			

01338

01338

(M)

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.
20535
MEMORANDUM
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, including a signature and date]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01411

01394

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 207 DEXTER PLACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY ETTA PRICE		4. DATE OF DEATH FEB. 1, 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-4-1891
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA, Artemas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS LEASURE		14. MOTHER'S MAIDEN NAME ANNABELL BARNES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No, (If yes give war or dates of service) None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 450.0 DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerosis, generalized DUE TO Cardiac decompensation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 7 days ? 7 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 11 p.m. 13	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) CUMBERLAND (County) ALLEGANY (State) MARYLAND
21. I certify that (I) (this hospital) attended the deceased from Jan 31, 1962 to Feb 1, 1962 that (I) (we) last saw the deceased alive on Jan 31, 1962, and that death occurred at 1:13 P.M. from the causes and on the date stated above.			
22a. SIGNATURE DR. GEORGE M. SIMONS M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/2/62
22c. PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS		22d. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/3/62	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City, town or county) Cumberland, Maryland (State)
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.		25a. REC'D BY REGISTRAR FEB 5 '62 DATE	25b. REGISTRAR'S SIGNATURE Arthur L. Hanks



0111

0111

ALLEGANY

WYOMING

CLEVELAND

CLEVELAND

1 DAY

RECTOR & WATKINS

200 DIXIE PLACE

MEMORIAL HOSPITAL

MARY

ETTS

PRICE

NO

1-1-1901

ELMWOOD

PENNSYLVANIA

ONE

THOMAS

AWARD

MEMORIAL HOSPITAL - CLEVELAND, OH.

WED

DR. GEORGE M. SIMONS

ALLEGANY HOSPITAL, CLEVELAND, OH.

CHARLES L. GEORGE, CLEVELAND, OH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01412

01395

1. PLACE OF DEATH e. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND,	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS RT. #2, WILLIAMS ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last WALTER R. REXROAD		4. DATE OF DEATH Month Day Year FEBRUARY 17 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 27 1901
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days 19 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUMBERLAND CEMENT & SUPPLY		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN E. REXROAD		14. MOTHER'S MAIDEN NAME REBECCA ROBISON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-7279	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 3 months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 18, 1962 to 2/17, 1962; that (I) (we) last saw the deceased alive on 2/17, 1962, and that death occurred at 1:25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE DR. GEORGE M. SIMONS		22b. DATE SIGNED 2/17/62	
22c. PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS		22d. ADDRESS ALGONQUIN HOTEL - CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/19/62	
23c. NAME OF CEMETERY OR CREMATORY Mt Herman Cemetery		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR DATE FEB 21 '62	
ADDRESS Cumberland Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

M

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Continued

George W. Sims
R. L. Sims

ALBION HOTEL - COVINGTON, LA.

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01413

CERTIFICATE OF DEATH

01396

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 10/28/1955 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Allegany County Infirmary				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 Cumberland d. STREET ADDRESS 1 622 Maryland Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eva Riehl First Middle Last 4. DATE OF DEATH February 3, 1962 Month Day Year				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 6/21/1878 9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Office 10b. KIND OF BUSINESS OR INDUSTRY Swifts Meat Company 11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Jacob Riehl 14. MOTHER'S MAIDEN NAME Christina Griesman				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial degeneration, Senile 4 43X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerosis & hypertension DUE TO (c) Cerebral degeneration				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/28/55 , 19...., to 2/3/62 , 19...., that (I) (we) last saw the deceased alive on 2/3/62 , 19...., and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Dr. Lee B. Mathews 22b. DATE SIGNED 2/5/1962				22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews 22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 7, 1962		23c. NAME OF CEMETERY OR CREMATORY TRINITY LUTHERAN CEMETERY		23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT ADDRESS CUMBERLAND, MD.				25a. REC'D BY REGISTRAR DATE FEB 6 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

01338

01313

M

Allegany

Maryland

Allegany

Camptobland

10/28/1955

628 Maryland Avenue

Allegany County, West Virginia

85

3

February

Right

545

83

6/21/1978

X

White

Female

U. S. A.

Camptobland, Maryland

White Male

Registered: Office

Christian Grissman

Jacob Right

Camptobland, Md.

P.O. Box 599

Allegany County, Maryland records.

2/1/62

10/28/55

9:30 P.M.

2/1/62

2/1/62

113 Greene St., Camptobland, Md.

Dr. Lee B. Nichols

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01414

01397

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 25 HRS. d. NAME OF HOSPITAL OR INSTITUTION (if not hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYNDMAN d. STREET ADDRESS 75X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) DOVE E. RITCHEY			4. DATE OF DEATH FEBRUARY 6, 1962										
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH FEB. 28, 1894		9. AGE (In years last birthday) 67 yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad 11. BIRTHPLACE (County & State, or foreign country) Hyndman, Pa. 12. CITIZEN OF WHAT COUNTRY? USA	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
13. FATHER'S NAME CLINTON RITCHEY			14. MOTHER'S MAIDEN NAME MARY FERNER										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 705-09-2589		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cholecystitis acute with cholelithiasis (b) 5870 DUE TO Pancreatitis acute hemorrhagic (c) 48 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystectomy Feb 5, 1962 48 hours													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 5, 1962</u> to <u>Feb 6, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 6, 1962</u>, and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE Wylie M. Faw, Jr. 22c. PHYSICIAN'S NAME (Type) DR. WYLIE M. FAW, JR.			22b. DATE SIGNED FEB 6 1962 22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 9, 1962		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery									
23d. LOCATION (City, town or county) (State) Hyndman, Pa.		25a. REC'D BY REGISTRAR DATE FEB 9 '62											
25b. REGISTRAR'S SIGNATURE Harvey H. Zeigler				25c. REGISTRAR'S SIGNATURE Arthur S. Kraus									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01007

CERTIFICATE OF DEATH

11111



DECEASED

PLUMMER

ALLGAIN

WILSON

25 HRS.

CONCRETE

GENERAL HOSPITAL

GENERAL HOSPITAL

WITNEY

DOVE

WHITE

WHITE

FEB. 25, 1904

1904

WILSON

WILSON

WILSON

CLINTON WITNEY

FOR-00-2015 MEMORIAL HOSPITAL - OBERLAND, N.Y.

DR. WILSON, JR.

FEB. 25, 1904

WILSON, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

1
M
60
I
2

01415

01398

Items 8 & 9, Birth cert. in this Division 2/20/62

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b. 9 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS RT. #4, BOX 65, OLDTOWN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOSEPH A. RUPPENKAMP		4. DATE OF DEATH FEBRUARY 8 19 62		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-9-1903		9. AGE (In years last birthday) 58 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MECH. HELPERB. & O. R.R.CO.		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH RUPPENKAMP		14. MOTHER'S MAIDEN NAME SOPHIA BRINKER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 217-10-1615		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal varices with hemorrhage 581.1 } DUE TO (b) A. S. heart disease with terminal congestive failure Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) Cirrhosis Liver, Laennec's type, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Gen. arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 week 2 years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Feb 8 1962		20g. (County) Allegany		20h. (State) Md.					
21. I certify that (I) (this hospital) attended the deceased from Feb 8 1962 to Feb 8 1962 that (I) (we) last saw the deceased alive on Feb 8 1962 and that death occurred at 11:10 P.M. from the causes and on the date stated above.		22a. SIGNATURE W. Alfred Van Ormer		22b. DATE SIGNED 10 Feb 62		22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. PHYS. <input checked="" type="checkbox"/>		22g. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 12, 1962		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) Cumberland, Md.		23e. (State) Md.		24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR FEB 14 '62		24b. REGISTRAR'S SIGNATURE Charles S. Thomas					

01333

CLINICAL OF DEATH

01333

M

ALLEGY

CHURCH

2 DAYS

CHURCH

MEMORIAL HOSPITAL

RT. F. BOX

JOSEPH A. GUNTERMAN

10-9-1903

WHITE

RETIRED MGR. BELL & CO. B.R.CO.

CHURCH BLVD. NEWARK, N.J.

JOSEPH BRINKER

JOSEPH BRINKER

17-18-1903 MEMORIAL HOSPITAL - CHURCH, N.J.

W. A. VAN COTT

123 S. CENTRE STREET, CHURCH, N.J.

JOSEPH A. GUNTERMAN

JOSEPH A. GUNTERMAN

JOSEPH A. GUNTERMAN

JOSEPH A. GUNTERMAN

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01416 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01399											
1. PLACE OF DEATH a. COUNTY Allegany						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY in 1b 68 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland				d. STREET ADDRESS 46 Utah Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Carl			Middle Henry			Last Schade		
4. DATE OF DEATH			Month Feb.			Day 23			Year 19 62		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 25, 1893		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction Co.				11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl H. Schade						14. MOTHER'S MAIDEN NAME Anna B. Hahn					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) War I yes						16. SOCIAL SECURITY NO. 214-05-6428		17. INFORMANT Mr. Arthur E. Schade, Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE											
DUO TO 422											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE ---											
DUO TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED Feb. 23, 1962		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Feb. 26, 1962		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland Md.	
23. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						24a. REC'D BY REGISTRAR MAR 1 '62		24b. REGISTRAR'S SIGNATURE Arthur E. Schade			

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01333

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01417

01460

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 1 29 ELDER ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT L. SETTLE		4. DATE OF DEATH Month Day Year FEB. 19 19 62	
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/93
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days 68	11. IF UNDER 24 HRS. Hours Min. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman		10b. KIND OF BUSINESS OR INDUSTRY Raliroad	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA Rappahanock		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ASHBY SETTLE		14. MOTHER'S MAIDEN NAME LUCY SETTLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MD.	
17. INFORMANT ASHBY SETTLE		Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis & Infection 4-20-1 DUE TO (b) Myocarditis & Decompensation 2 yrs Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) Arteriosclerosis 5 yrs		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 9, 1962 to July 19, 1962 that (I) (we) last saw the deceased alive on July 19, 1962 and that death occurred at 9:45 AM from the causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett M.D.		22b. DATE SIGNED 7/20/62	
22c. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT		22d. ADDRESS 236 VIRGINIA AVE. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-22-62	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR FEB 26 '62	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Francis	

01900

01911

(M)

ALLEGANY

MARTLAND

CUMBERLAND

3 DAYS

CUMBERLAND

ED CLINE ST.

THE CRUEL HOSPITAL

SETTLE

ROBERT

FEB. 13

11093

WHITE

U.S.A.

LUCKY SETTLE

BY SETTLE

MEMORIAL HOSPITAL, CUMBERLAND, MD.

Examination of the patient's condition
on February 13, 1900
at the Memorial Hospital, Cumberland, Md.

Chief Complaint
History of Present Illness
Physical Examination
Diagnosis
Prognosis
Treatment

336 VIRGINIA AVE., CUMBERLAND, MD.

DR. RAY BOWLEY

2

James P. Postnell, Cumberland, Md.

1
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01418 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					01401						
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>40 Years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>12 Cumberland</u>			d. STREET ADDRESS <u>320 Bedford Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>320 Bedford Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Blaine Shewbridge</u>					4. DATE OF DEATH Month Day Year <u>February 22 19 62</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 26, 1884</u>		9. AGE (In years last birthday) <u>77</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Celanese Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Benjamin Shewbridge</u>					14. MOTHER'S MAIDEN NAME <u>Mary Finn</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>217-10-5666</u>		17. INFORMANT <u>Mrs. Bessie Shewbridge</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , (inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Feb. 22, 1962</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>2/25/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Herman Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR <u>Ruth E. Silcox</u> <u>Cumberland</u> <u>Maryland</u>					24a. REC'D BY REGISTRAR <u>FEB 26 '62</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01419

01402

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE MARYLAND f. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND Rt #1 d. STREET ADDRESS BOWMAN'S ADDITION e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDMOND SHIPLEY		4. DATE OF DEATH Month FEBRUARY Day 17 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 31, 1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 17	11. IF UNDER 24 HRS. Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired B & O Employee Maintenance Dept		10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME DOSH SHIPLEY		14. MOTHER'S MAIDEN NAME MARTHA GRIMM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-03-9507	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Chemia DUE TO (b) Chronic Glomerulonephritis DUE TO (c) 4 yrs		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 Feb , 19 62 , to 17 Feb , 19 62 ; that (I) (we) last saw the deceased alive on 17 Feb , 19 62 , and that death occurred 10:45 AM from the causes and on the date stated above.			
22a. SIGNATURE JAMES G. STEGMAIER M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JAMES G. STEGMAIER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/20/62	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR DATE FEB 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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ALLEGANY

ALLEGANY

ALLEGANY

CUMBERLAND

5 DAYS

CUMBERLAND

BOWLING ADDITION

MC CRACK HOSPITAL

SE

SHIRLEY

EDWARD

JULY 31, 1930

WHITE

PENNSYLVANIA

EDWARD & J. J. JONES

WAXING GRIM

BOSS SHIRLEY

CUMBERLAND, MD.

MC CRACK HOSPITAL

WILLIAM J. STEINER

JAMES G. STEINER

122 S. CENTER ST., CUMBERLAND, MD.

WILLIAM J. STEINER

CUMBERLAND

ALLEGANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01420 CERTIFICATE OF DEATH 01403										
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG			c. LENGTH OF STAY in lb 7 HRS.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG			d. STREET ADDRESS 1 108 W. MAIN ST.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM W. SLUSS					4. DATE OF DEATH Month Day Year FEB. 24, 19 62					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 30, 1878		9. AGE (In years last birthday) 83 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GROCER		10b. KIND OF BUSINESS OR INDUSTRY OWN STORE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LOUIS SLUSS					14. MOTHER'S MAIDEN NAME ANNA M. SHULTZER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 214-32-3507					17. INFORMANT Address WM. W. SLUSS, JR. FROSTBURG, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH 3 days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) X					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. X 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State) X			
21. I certify that (I) (this hospital) attended the deceased from SEPT. 19 55 to 2/24, 19 62 , that (I) (we) last saw the deceased alive on 2/24, 19 62 , and that death occurred at 2 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Martin Rothstein, M.D.					22b. DATE SIGNED 2/26/62					
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.					22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF FEB. 27 '62		23c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK			23d. LOCATION (City, town or county) (State) FROSTBURG, MD.		
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Duret					ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE MAR 1 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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JOHN W. BROWNE

JOHN W. BROWNE

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01421

Item 8 Film G308

3/5/62 ink

01404

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 26 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 100 NEW HAMPSHIRE AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle M. Last SPRING				4. DATE OF DEATH Month FEB. Day 21 Year 1962			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/31/1887 1886	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 21		IF UNDER 24 HRS. Hours 2 Min. 21			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERK				10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT		11. BIRTHPLACE (County & State, or foreign country) MARYLAND -HANCOCK,	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DECEASED Jacob F. Mouse				14. MOTHER'S MAIDEN NAME DECEASED Loretta Ortman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)				16. SOCIAL SECURITY NO. CHART			
17. INFORMANT CHART				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 422 Congestive Heart Failure DUE TO (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 3 months DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 26 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/4 1962 , to 2/21 1962 , that (I) (we) last saw the deceased alive on 2/21 1962 , and that death occurred at 7 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Weissman M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/23/62	
22c. PHYSICIAN'S NAME (Type) S. G. Weissman				22d. ADDRESS 59 Greave St Cumberland Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 24, 1962		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 27 '62	
				25b. REGISTRAR'S SIGNATURE Carlton S. Kinn			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 Film G307 2/23/62 iwk

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b 5 minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart, Md. d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ORVILLE G. STEELE		4. DATE OF DEATH 2 14 19 62	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-1962/ 1902 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	9. AGE (In years last birthday) 59 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Zihlman, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Steele		14. MOTHER'S MAIDEN NAME Daisy Mustetter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. 213-09-6546	
17. INFORMANT Mrs. Myrtle Steele, Eckhart, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rt. Lung DUE TO (b) 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 6 months +			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Summer 19 61 , to February 19 62 , that (I) (we) last saw the deceased alive on Feb. 1 19 62 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Calvin Y. Hadidian 22c. PHYSICIAN'S NAME (Type) CALVIN Y. HADIDIAN		22b. DATE SIGNED 2/15/62 22d. ADDRESS ALBONQUIN HOTEL, Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/18/62	23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	23d. LOCATION (City, town or county) (State) Frostburg Md.
24. FUNERAL DIRECTOR'S SIGNATURE Boulah H. Montesant ADDRESS 23 E. Main, Frostburg, Md.		25a. REC'D BY REGISTRAR FEB 20 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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21
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01423 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01408

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 236 E. MAIN STREET			
3. NAME OF DECEASED (Type or print) ALLEN HARRISON STEWART				4. DATE OF DEATH FEBRUARY 27TH, 19 62			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 27TH, 1888	9. AGE (In years last birthday) 73 Yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET.-CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY RAILROADING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN STEWART				14. MOTHER'S MAIDEN NAME ANNA MARY PENGELLY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 712-14-1585		17. INFORMANT MRS. DOROTHY V. CLOSE, FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) CORONARY SCLEROSIS DUE TO (c) ---							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) APLASTIC ANEMIA							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19	Month, Day, Year 3-2-62	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) FROSTBURG	(County) ALLEGANY	(State) MARYLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> FEBRUARY 27, 1962 Address (Street, city, town, or county) Cumberland, Md.							
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county) Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-2-62	22c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		22d. LOCATION (City, town, or country) (State) ECKHART, MD.			
23. FUNERAL DIRECTOR J. R. Duost				24a. REC'D BY REGISTRAR DATE MAR 5 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

01408

(M)

Remitté

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01424 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01407

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland, Maryland</u>		d. STREET ADDRESS <u>106 Hanover Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>106 Hanover Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Benédict</u> Last <u>Sturtz</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>7</u> Year <u>19 62</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/18/1897</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Simon P. Sturtz</u>				14. MOTHER'S MAIDEN NAME <u>Clara Dickel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes <u>W. War I</u>		16. SOCIAL SECURITY NO. <u>213-22-3198</u>		17. INFORMANT Address <u>Mrs. Mary Sturtz 106 Hanover St. Cumberland, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420. } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <u>CORONARY SCLEROSIS WITH THROMBOSIS</u> (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>February 7, 1962</u> EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>R9 Cumberland, Md.</u> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks Catholic Cem. Cumberland, Maryland</u>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>John J. Hafer, Cumberland Maryland</u>				24a. REC'D BY REGISTRAR <u>Feb 13 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>			

MEDICAL CERTIFICATION

01107

01107

(M)

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
01425						01408									
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY						
Allegany			Cumberland Md.			Maryland			Allegany						
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS						
849 Mt Royal Ave.			849 Mt Royal Ave.			02 Cumberland, Md.			1 849 Mt Royal Ave.						
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH									
Elizabeth Frances Summers						Feb. 4, 1962									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. UNDER 1 YEAR					
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan 20, 1919		43 yrs.		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Time Clerk				Kelly Springfield				Chicago Ill.		U.S.A.					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME									
William M. Ritchey						Marie Trigg									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT			
No						229-46-2382						Turner T. Summers Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e).												410X			
DUE TO												Chronic valvular heart disease, mitral with insufficiency, and congestive failure			
DUE TO												20 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).												19. WAS AUTOPSY PERFORMED?			
Rheumatic fever, 1955, history of												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY			
20c. TIME OF INJURY						20d. INJURY OCCURRED						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
Hour e.m. p.m.						While et work Not White et work						20f. (City or town) (County) (State)			
19												May 1960 to 4 Feb. 1962			
21. I certify that (I) (this hospital) attended the deceased from May 1960 to 4 Feb. 1962 that (I) last saw the deceased alive on 31 Dec. 1961, and that death occurred at 6 PM, from the causes and on the date stated above.												22a. SIGNATURE		22b. DATE SIGNED	
W. Alfred Van Ormer						M.D.						5 Feb. 62			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS						22e. REGISTRAR'S SIGNATURE			
W. Alfred Van Ormer, M. D.						122 S. Centre Street, Cumberland, Maryland						Carling L. Thomas			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)						
Burial			2/6/62			Hickory Hill Cem.			Cumberland Md.						
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE			
Laurie Stein Inc.						Cumb. Md.						DATE FEB 7 '62			

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01426 CERTIFICATE OF DEATH 01409

1. PLACE OF DEATH e. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in corporate limits, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS RT. #3, BEDFORD ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LESTER TEWELL		4. DATE OF DEATH FEB. 7, 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Driver		10b. KIND OF BUSINESS OR INDUSTRY Oil Company	11. BIRTHPLACE (County & State, or foreign country) ARTEMAS, PA.
13. FATHER'S NAME WILLIAM TEWELL		14. MOTHER'S MAIDEN NAME HARRIETT SHIPLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214 07 1277	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (b) Coronary Artery Disease, advanced (c) 5 hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 8:25 1960 to Feb. 7, 1962 that (I) (we) last saw the deceased alive on Feb. 7, 1962 and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE William P. James		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/8/62
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22d. ADDRESS 411 N. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 11, 1962	23c. NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park	23d. LOCATION (City, town or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
25a. REC'D BY REGISTRAR FEB 13 '62		25b. REGISTRAR'S SIGNATURE Wm. S. Thomas	

01303

CENTRAL STATE OF CALIFORNIA

01303

M

SUGGESTION

CO. 200-100

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

LESTER

LESTER

WHITE

0-1-1901

HAROLD T. SMITH

WILLIAM T. SMITH

MEMORIAL HOSPITAL - CO. 200-100

2

Conway Nelson, Jr.
Conway Nelson, Jr.

DR. WILLIAM T. SMITH

DR. WILLIAM T. SMITH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
01427		01410	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY	ALLEGANY	a. STATE	West Virginia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	CUMBERLAND	b. COUNTY	Mineral
c. LENGTH OF STAY IN 1b	12 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	R.D. (P.O. Kitzmiller, Md.)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	SACRED HEART HOSPITAL	d. STREET ADDRESS	Potomac Manor, W.Va.
3. NAME OF DECEASED (Type or print)	First HELEN Middle M Last TRANIM	4. DATE OF DEATH	Month 2 Day 25 Year 1962
5. SEX	FEMALE	6. COLOR OR RACE	WHITE
7. MARRIED	<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	90 11/29/62
9. AGE (In years last birthday)	71 yrs.	IF UNDER 1 YEAR	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Housework	10b. KIND OF BUSINESS OR INDUSTRY	Own Home
11. BIRTHPLACE (County & State, or foreign country)	MD.	12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME	Theodore Spiker	14. MOTHER'S MAIDEN NAME	Anna Duckworth
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)	No	16. SOCIAL SECURITY NO.	213-01-6603B
17. INFORMANT	CHART - Mrs. Delbert Michaels,	Address	R.D. 5
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral Venous Thrombosis	INTERVAL BETWEEN ONSET AND DEATH	2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) Hypertensive C.V. Disease	DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/20, 1962 to 2-25, 1962, that (I) (we) last saw the deceased alive on 2-25, 1962, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE	22b. DATE	22c. PHYSICIAN'S NAME (Type)	
B.M. Schindler	2/26/62	DR. B.M. SCHINDLER	
22d. ADDRESS	22e. REC'D BY REGISTRAR		
86 GREENE STREET	25b. REGISTRAR'S SIGNATURE		
23a. BURIAL, CREMATION, (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	2/27/62	I.O.O.F. Cemetery	Elk Garden, W.Va.
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
Amy Mildred Sharpless		25b. REGISTRAR'S SIGNATURE	
ADDRESS		DATE	
Blaine, W.Va.		MAR 2 '62	

5510

1210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01428

01411

M

PLACE OF DEATH

a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

ROUTE 1, FROSTBURG

c. LENGTH OF STAY IN

50 YRS.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

MARYLAND

b. COUNTY

ALLEGANY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

ROUTE 1, FROSTBURG

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)

First

WILLIAM

Middle

L.

Last

WALKER

4. DATE OF DEATH

Month

FEBRUARY

Day

18TH, 1962

Year

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

MARCH 27TH, 1878

9. AGE (In years last birthday)

83 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RET.*CUSTODIAN

10b. KIND OF BUSINESS OR INDUSTRY

COUNTY BLDG.

11. BIRTHPLACE (County & State, or foreign country)

SCOTLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM WALKER

14. MOTHER'S MAIDEN NAME

AGNES SPEIR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

220-10-9346

17. INFORMANT

Address

MRS. EDITH A. WALKER, RT. 1, FROSTBURG, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

6 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.Month, Day, Year
1920d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Feb 15, 1962 to Feb 18, 1962 that (I) (we) last saw the deceased alive on Feb 18, 1962, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

W. O. McLANE,

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐STAFF PHYS. ☐

22b. DATE SIGNED

22d. ADDRESS

167 E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

2-21-62

23c. NAME OF CEMETERY OR CREMATORY

F'B.G. MEMORIAL PARK

23d. LOCATION (City, town or county)

FROSTBURG,

(State)

MD.

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

FROSTBURG, MD.

25a. REC'D BY REGISTRAR

FEB 23 '62

25b. REGISTRAR'S SIGNATURE

Arthur L. Kraus

01111

01111



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01429

01412

1. PLACE OF DEATH e. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 20 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORRIGANVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARA A. WALTERS				4. DATE OF DEATH Month FEBRUARY Day 5 Year 1962			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 21, 1897	
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months 6 Days 4		IF UNDER 24 HRS. Hours 6 Min. 4			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese, Kelly-Springfield Factory				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HARRY WALTERS				14. MOTHER'S MAIDEN NAME IDA COOLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 230-24-0195		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senear-Usher Syndrome 704.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobular Pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mo. 2 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. — p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 Dec , 1961, to 4 Feb , 1962, that (I) (we) last saw the deceased alive on 4 Feb , 1962, and that death occurred 8:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Mark M. Kroll				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5 Feb 62	
22c. PHYSICIAN'S NAME (Type) MARK M. KROLL				22d. ADDRESS 110 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 8, 1962		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens Cumberland, Md. RD		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Heigler				ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR 13 '62	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

01415

01415

ALLEGANY

WYOMING

ALLEGANY

CORRIGANVILLE

20 DAYS

CUMBERLAND

MC CRAL HOSPITAL

FEBRUARY 2

WATERS

CLARK, A.

ON

SEPT. 21, 1931

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WHITE

WHITE

U.S.A.

CUMBERLAND, WYOMING

THE COURT

DOCTOR RAY

WATKINSON

CUMBERLAND, WY.

105 MC CRAL HOSPITAL

MARK H. KROLL

110 S. CENTRE ST., CUMBERLAND, WY.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01413

01430

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN, Rt. # 5 Cumb. Md. d. STREET ADDRESS 123 Meadow Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETHEL MAE WENRICH		4. DATE OF DEATH FEB 24 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1903
9. AGE (In years last birthday) 58^{rs}		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) Ridgeley, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Oliver W. Summers	
14. MOTHER'S MAIDEN NAME Amanda R. Dixon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Joseph G. Wenrich 123 Meadow Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Coronary Thrombosis 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 15, 1962 to Feb 24, 1962 that (I) (we) last saw the deceased alive on Feb 23, 1962 and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE DR. B. M. SCHINDLER		22b. DATE SIGNED 2/26/62	
22c. PHYSICIAN'S NAME (Type) DR. B. M. SCHINDLER		22d. ADDRESS XXX GREENE STREET 43	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/62	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.		25a. REC'D BY REGISTRAR FEB 28 '62	
25b. REGISTRAR'S SIGNATURE Charles E. Thomas			

01110

STATE OF TEXAS

01110

(M)

[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side. Some fragments are visible, such as "STATE OF TEXAS" and "COUNTY OF DALLAS".]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01431

01414

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 201 Rock		d. STREET ADDRESS 1 201 Rock	
3. NAME OF DECEASED (Type or print) First Howard Middle Ervin Last Whisner		4. DATE OF DEATH Month Feb. Day 27 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1892
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. Mineral (County & State, or foreign country) W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Whiner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 236-03-3866	
17. INFORMANT Carl Whisner-Bloomington, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arterio-sclerosis with Hypertension DUE TO (c) Ten Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 10, 1953 to Feb. 27, 1962 , that (I) (we) last saw the deceased alive on Feb 10, 1962 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson		22b. DATE SIGNED Feb. 28, 1962	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson		22d. ADDRESS Piedmont, W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/1/62	
23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ed. B. ...		25a. REC'D BY REGISTRAR DATE 2 '62	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. ...	

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Feb 10 1962

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01415

01432

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 716 N. Centre St.,		d. STREET ADDRESS 716 N. Centre St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Francis Last Wigger		4. DATE OF DEATH Month Feb. Day 24, Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1903
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deliveryman		10b. KIND OF BUSINESS OR INDUSTRY Brewery	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James B. Wigger		14. MOTHER'S MAIDEN NAME May Shank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 214-05-5015	
17. INFORMANT Mrs. Leona Wigger		Address Cumb. Md. 716 N. Centre St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Cervical Glands 198.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Metastases DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X	
20c. TIME OF INJURY Hour o. m. p. m. X 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/19/46 , 19____, to 2/24 , 1962, that I last saw the deceased alive on 2/24/62 , 19____, and that death occurred at 1:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2/26/62			
ACTUAL SIGNATURE L. B. Mathews M.D.		PHYSICIAN'S NAME (Type) 49 Green St. Cumberland Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/27/62	22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE FEB 28 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1132

MAKLAND STATE DEPARTMENT OF HEALTH
BIRMINGHAM, ALA.

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
J. M. Smith		Male		45		1910		1955		Home		Heart Disease		Natural		J. M. Smith		J. M. Smith	
Occupation		Education		Marital Status		Previous Illnesses		Last Illness		Time of Death		Time of Day		Time of Year		Time of Month		Time of Day	
Teacher		High School		Married		None		Chest Pain		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Place of Birth		Place of Residence		Place of Burial		Place of Interment		Place of Cremation		Place of Disposition		Place of Disposition		Place of Disposition		Place of Disposition		Place of Disposition	
Alabama		Alabama		Alabama		Alabama		Alabama		Alabama		Alabama		Alabama		Alabama		Alabama	
County		City		Town		Village		Hamlet		Census Tract		Precinct		Ward		District		Division	
Jefferson		Birmingham		Birmingham		Birmingham		Birmingham		Birmingham		Birmingham		Birmingham		Birmingham		Birmingham	
Street		Avenue		Boulevard		Parkway		Expressway		Freeway		Interstate		Highway		Road		Lane	
1234		5678		9101		2345		6789		0123		4567		8901		2345		6789	
Zip Code		Phone Number		Telex Number		Radio Number		Cable Number		Mail Number		Post Office		Post Office		Post Office		Post Office	
35201		234-5678		1234567		9876543		4567890		1234567		9876543		4567890		1234567		9876543	
Registrar's Office		Registrar's Office		Registrar's Office		Registrar's Office		Registrar's Office		Registrar's Office		Registrar's Office		Registrar's Office		Registrar's Office		Registrar's Office	
Birmingham, Ala.		Birmingham, Ala.		Birmingham, Ala.		Birmingham, Ala.		Birmingham, Ala.		Birmingham, Ala.		Birmingham, Ala.		Birmingham, Ala.		Birmingham, Ala.		Birmingham, Ala.	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01433

CERTIFICATE OF DEATH

01416

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LONA CONING	
d. NAME OF HOSPITAL OR PLACE OF DEATH (if not in institution, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		d. STREET ADDRESS DOUGLAS AVE., BOX 106	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS C. WILHELM		4. DATE OF DEATH Month Day Year FEB. 8, 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-1885
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME OLIN WILHELM		14. MOTHER'S MAIDEN NAME CATHERINE GARLITZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 219-03-8049	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 443X DUE TO (b) Hypertensive and arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) Sen. arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 years ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7 Mar. 2:20 P.M. to 8 Feb. 1962 that (I) (we) last saw the deceased alive on 8 Feb. 1962 and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer, M.D.		22b. DATE SIGNED 10 Feb. 62	
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/11/1962	23c. NAME OF CEMETERY OR CREMATORY St. Anns Cemetery	23d. LOCATION (City, town or county) (State) Avilton, MD. (Garrett, CO.
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		25a. REC'D BY REGISTRAR FEB 13 '62	
ADDRESS LONA CONING, MD.		25b. REGISTRAR'S SIGNATURE William S. Thane	

M

01118

01118

ALLIANCE

CUMBERLAND

MEMORIAL HOSPITAL

FRANCIS

WHITE

Colored Coal Miner

OLIM VILIELM

210-03-1018

MEMORIAL HOSPITAL - CUMBERLAND, MD.

CATHOLIC CHURCH

HARVARD

FEB. 8

2-1-1935

U. S. A.

DR. W. A. VAN ORSER

122 S. CENTRE ST., CUMBERLAND, MD.

BRISTOL

2/11 1935

LOWACOMING, MD.

GEORGE HICKORN

WALTON, MD. (GARY, CO.)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 7/61

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01434

01417

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in 1b 28 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 1 304 COLUMBIA STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LOTTIE L. WILLIAMSON		4. DATE OF DEATH FEBRUARY 24 1962					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 3, 1893		9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) LEVELS, W. VA.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME FRANK SHANHOLTZER			14. MOTHER'S MAIDEN NAME ALMETA DURST				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.0 DUE TO Carcinoma of Breast with Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Oct 1961							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1955, 19, to Feb 62, 19, that (I) (we) last saw the deceased alive on Feb 23, 1962, and that death occurred 12:35 PM from the causes and on the date stated above.							
22a. SIGNATURE G. OVERTON HIMMELWRIGHT		22b. DATE SIGNED 2/27/62		22c. PHYSICIAN'S NAME (Type) G. OVERTON HIMMELWRIGHT			
22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/62		23c. NAME OF CEMETERY OR CREMATORY Levels Cemetery			
23d. LOCATION (City, town or county) Levels, W. Va.		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		24b. ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE MAR 1 '62			
25b. REGISTRAR'S SIGNATURE							

01113

01134



ALBANY

COVINGTON

20 DAYS

PORTLAND

COVINGTON

301 COLUMBIA ST.

MEMORIAL HOSPITAL

LOTTIE

L. WILLIAMS

YOUNG

FEMALE

MAY 3, 1901

68

LEWIS, W. W.

0.8.1

BRANK SMITHSON

ALTA DIST

MEMORIAL HOSPITAL

COVINGTON, LA.

G. OVERTON HILL

123 VIOLET AVE., COVINGTON, LA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
01435 01418													
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY IN b 3 WKS.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL				d. STREET ADDRESS 1									
3. NAME OF DECEASED (Type or print) WILLIAM B. WINEBRENNER				4. DATE OF DEATH FEBRUARY 2nd, 19 62									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 28th, 1903		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK SETTER				10b. KIND OF BUSINESS OR INDUSTRY BRICK PLANT				11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM M. WINEBRENNER				14. MOTHER'S MAIDEN NAME SUSAN WHETZEL									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 214-01-0111				17. INFORMANT MRS. JOHN EVANS, MIDLOTHIAN, MD.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 33 IX DUE TO (b) Cerebral vascular hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 days 3 wks years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Feb 2, 1962 , that (I) (we) last saw the deceased alive on Feb 1, 1962 , and that death occurred at AM , from the causes and on the date stated above.													
22a. SIGNATURE Leslie R. Miles MD				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) LESLIE R. MILES,				22d. ADDRESS E. MAIN ST., LONACONING, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-5-62		23c. NAME OF CEMETERY OR CREMATORY METHODIST CEMETERY				23d. LOCATION (City, town or county) (State) MT. SAVAGE, MD.					
24 FUNERAL DIRECTOR'S SIGNATURE J. R. Burst				ADDRESS FROSTBURG, MD.				25a. REC'D BY REGISTRAR DATE FEB 5 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

01118

01138

